

# Health statement



## Keeping your information confidential

Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers and reinsurers who, in some instances, may be located in jurisdictions outside Canada. Your personal information may be subject to the laws of those foreign jurisdictions. Sun Life Financial's operations worldwide and our third-party providers are required to protect the confidentiality of your personal information in a manner that is consistent with our privacy policy and practices.

To find out about our Privacy Policy, visit our website at [www.sunlife.ca](http://www.sunlife.ca), or to obtain information about our privacy practices, send a written request by email to [privacyofficer@sunlife.com](mailto:privacyofficer@sunlife.com), or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

### Important

- Incomplete forms will delay processing.
- Part 1 is to be completed by the plan administrator or the plan member with information provided by the plan administrator.
- Plan member to mail form directly to Sun Life Assurance Company of Canada.

Please PRINT clearly.

## 1 Plan administrator information (to be completed by the plan administrator or the member)

Coverage is not in effect until you receive notice of approval from Sun Life Assurance Company of Canada.

Member's last name		Member's first name		Contract number	
Occupation			Class	Billing group	Member ID
Current salary \$	<input type="checkbox"/> Hrly. <input type="checkbox"/> Wkly. <input type="checkbox"/> Bi-Wkly. <input type="checkbox"/> Mthly. <input type="checkbox"/> Ann.	Company name		Plan administrator's name	
Company street address		City	Province	Postal code	Telephone number -   -

### Reason for application

- New enrolment – effective date (dd-mm-yyyy)
- Increased coverage
- Late applicant (enrolled after 31 days)
- Re-application (previously declined)
- Annual enrolment – effective date (dd-mm-yyyy)

### Benefits requested

(Please check off)

	A. Existing amount of coverage (if applicable)	B. New amount of coverage requested	C. Total amount of coverage (A + B)
<input type="checkbox"/> Basic Life – member	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Basic Life – spouse	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Basic Life – dependent	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Optional Life – member	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Optional Life – spouse	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Optional Life – dependent	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Critical Illness – member	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Critical Illness – spouse	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Critical Illness – dependent	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Long-term disability	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Short-term disability	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Other _____	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>
<input type="checkbox"/> Extended Health – member*	New benefit <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Extended Health – dependent*	New benefit <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Dental – member*	New benefit <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Dental – dependent*	New benefit <input type="checkbox"/> Yes <input type="checkbox"/> No		

\* If applicable – Date of loss of comparable coverage (dd-mm-yyyy)

## 2 Member and dependent details (to be completed by the member)

### 2.1 General information about the member

Member's last name		Member's first name			Date of birth (dd-mm-yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Member's street address (street number and name)				Apartment or suite	City	Province Postal code
Please provide all applicable contact information where you can be reached for additional information						
Home telephone number <input type="checkbox"/> Day <input type="checkbox"/> Evening		Business telephone number <input type="checkbox"/> Day <input type="checkbox"/> Evening		Preferred method of contact <input type="checkbox"/> Mail <input type="checkbox"/> Email		
Email address: _____						
Height ft. in.   m cm		Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg		Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain _____ <input type="checkbox"/> Loss _____		Reason for weight change <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Date and reason for your last consultation with attending doctor (if no attending doctor, please state none)						
Name of doctor, diagnosis, treatment given, results, medication prescribed						
If the doctor named above does not have the most complete records of your medical history, please provide full name and address of the doctor who does have them						

### 2.2 General information about the member's dependents (complete this section only if applying for dependent coverage)

Spouse's last name		Spouse's first name			Date of birth (dd-mm-yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Height ft. in.   m cm		Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg		Change in weight in the last 12 months <input type="checkbox"/> No change <input type="checkbox"/> Gain _____ <input type="checkbox"/> Loss _____		Reason for weight change <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Date, reason and results for your dependent's last consultation with attending doctor (if no attending doctor, please state none)						
Name of doctor, diagnosis, treatment given, results, medication prescribed						
If the doctor named above does not have the most complete records of your dependent's medical history, please provide full name and address of the doctor who does have them						

Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height ft. in.   m cm	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height ft. in.   m cm	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Child's last name	Child's first name	Date of birth (dd-mm-yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height ft. in.   m cm	Weight <input type="checkbox"/> lbs. <input type="checkbox"/> kg

### 2.3 Family history information

Have any of your or your spouse's immediate family members (parents, brothers, sisters) had heart disease, heart attack, high blood pressure, polycystic kidney disease, familial polyposis of the bowel, stroke, diabetes, cancer (specify type below), multiple sclerosis, Huntington's Chorea, Alzheimer's, Parkinson's, ALS (Amyotrophic Lateral Sclerosis) or any hereditary disease?

Member	Spouse
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes, complete chart below.

#### Plan member's family history

Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father			
Mother			
Brother(s)			
Sister(s)			

#### Spouse's family history

Which condition(s)	Age at onset	Current age (if living)	Age at death (if applicable)
Father			
Mother			
Brother(s)			
Sister(s)			

## 2 Member and dependent details (continued)

### 2.4 Medical information (complete this section only for person(s) applying for insurance)

Complete section(s) 2.4, 2.5 and/or 2.6, as applicable, with any additional comments to these questions.

If you answer "yes" to any questions, please provide further details on the next page. Include dates, treatment, medications and results.

	Member	Spouse	Child(ren)
1. Have you ever:			
a) Been admitted to a hospital or clinic as a patient (except for pregnancy or birth) for longer than five consecutive days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Received disability benefits for three months or longer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Been declined or offered Life, Disability or Critical Illness insurance at a higher than standard risk? (If yes, specify name of insurer, date and reason)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you used any tobacco products within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the last 10 years, have you used cocaine, hashish, heroin, narcotics, marijuana, LSD, hallucinogens, amphetamines, except as prescribed by a doctor, or sought or received advice or treatment for the use of drugs (over-the-counter, prescribed or non-prescribed)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you consume alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a) Average number of drinks per week _____			
b) Have you ever been advised to stop drinking, to drink less or received treatment for the use of alcohol? Who _____ (e.g. spouse, friend, doctor, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reason _____ Date (dd-mm-yyyy) _____			
5. Are you presently under medical treatment by diet, medicine or other means? (provide details including names of all medications and reason(s) why you are using them)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever had diabetes, impaired sugar levels or ever had sugar, blood or protein in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your current treatment for diabetes?	Insulin: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Oral medication: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Diet only: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you ever had or received treatment for, consulted a doctor or other health practitioner for, or been diagnosed as having any one of the following:			
a) Cancer, malignancy, leukemia, enlarged lymph nodes, lymph gland disorder, tumours, polyps or other growths including moles, breast lumps or cysts, had a biopsy for any reason or had an abnormal cancer screening test?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Illnesses of the heart or circulatory system, including chest pain, abnormal electrocardiogram (ECG), irregular pulse, heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Liver disorder or any type of hepatitis or blood disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Disease or disorder of the kidneys, urinary tract, bladder, prostate or reproductive organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Chronic lung or respiratory disorder (including asthma and sleep apnea), disease or disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Transient ischemic attack (TIA), paralysis, seizure, epilepsy, multiple sclerosis, Alzheimer's, Parkinson's or any other disease or disorder of the brain or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Psychiatric or psychological problems (including anxiety, depression, panic attacks, eating disorders, any other emotional disorders) or been counselled for such?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Chronic fatigue syndrome, fibromyalgia, rheumatic/arthritis disease or lupus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Musculoskeletal, joint or bone disorders, paralysis or numbness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Back and neck problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) High cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m) Gastrointestinal disorder (including esophageal, stomach, colon, colitis or bowel/intestinal disorders)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you ever tested positive for AIDS, ARC or HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever suffered a heart attack or myocardial infarction?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever had a stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever had an organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever had any other illness, disease or disorder, condition, injury, diagnostic testing or surgical procedure not listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you ever used any special medical equipment or appliances such as a walker, cane, wheelchair, catheter, oxygen tank, pacemaker, artificial limb or hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Do you require assistance of any kind to perform any daily activities, such as bathing, continence, dressing, eating, using the toilet or transferring (for example: bed to chair)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Have you ever had any health symptoms or complaints for which a doctor has not been consulted or been advised to have further examinations or tests which have not been completed yet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 2 Member and dependent details (continued)

If you answered yes to any questions in the previous section, please provide further details. Use a separate sheet of paper if you need more space but ensure all additional sheets are signed, dated and stapled to this form.

### 2.5 Additional medical details – Member

Question	Further details

### 2.6 Additional medical details – Dependent Spouse/Children

Question	Dependent name	Further details

## 3 Declaration and authorization (please read and sign this section)

In this declaration and authorization, "I" applies to each of the member, the spouse and the child(ren) age 18 and older signing below. I understand I may be refused those group benefits or any benefit amounts for which proof of good health is required if, in the opinion of Sun Life Assurance Company of Canada, I am not insurable. I certify that all the statements in this form are true and complete and I understand that concealment, misrepresentation and false declaration concerning this Health statement, will cause the insurance to be void. I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and disclose information needed for underwriting, administrating and adjudicating claims under this Plan with any person or organization who has relevant information about me and/or my dependents under age 18 (if applicable), pertaining to this Health statement. This includes any health professionals, institutions, investigative agencies, insurers and reinsurers.

If I am a spouse or dependent age 18 and older, I also authorize Sun Life Assurance Company of Canada to disclose information about this application to the member, for the purposes of assessing this application and managing the group benefits plan.

I agree that a photocopy of this authorization or electronic version is as valid as the original and shall continue to have effect throughout the duration of my coverage under this group contract, unless withdrawn in writing.

Signature of member X	Date (dd-mm-yyyy) — —
Signature of spouse X	Date (dd-mm-yyyy) — —
Signature of dependent child 18 years or older X	Date (dd-mm-yyyy) — —
Signature of dependent child 18 years or older X	Date (dd-mm-yyyy) — —

Sun Life Assurance Company of Canada must receive your completed Health statement within 60 days of the date you complete, sign and date the form, otherwise you will need to submit a new Health statement.

All information received by Sun Life Assurance Company of Canada is treated as strictly confidential and is used for the sole purpose of determining your eligibility and administering the group plan to which you belong. Returning your forms and medical information to us in a confidential envelope ensures that only our medical underwriters will have access to them. Please fully complete the address.

**Send the completed form to one of the following addresses in an envelope marked "Confidential" and retain a copy for your records.**

**Toll-free fax number: 1-877-897-5519**  
Sun Life Assurance Company of Canada  
Medical Underwriting  
Private and Confidential  
PO Box 11691 Stn CV  
Montreal QC H3C 3J9

**Toll-free fax number: 1-877-897-6605**  
Sun Life Assurance Company of Canada  
Medical Underwriting  
Private and Confidential  
PO Box 578 Stn Waterloo  
Waterloo ON N2J 4B8

**Toll-free number: 1-866-882-0884**

Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.